NOVA Medical School/Faculdade de Ciências Médicas

Universidade NOVA de Lisboa

Policing and planning:

Deinstitutionalization of mentally ill in Georgia

Project work of Master in Mental Health Policy and Services

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2016

Contents

Abstract

Worldwide, 12% of total disability adjusted life years lost (DALYs) are caused by mental and behavioral disorders, which exceeds the global burden caused by cardiovascular conditions (9.7%) and malignant tumors (5.1%) (WHO, 2001). Despite the fact that mental disorders have considerable negative effects on the quality of life, low- and middle-income countries spend less than 2% of total national health care budget and large share of spending is diverted towards institutional psychiatric care.

Georgia is a middle income country, where drastic reforms in the national mental health policy started from 2014. One of the key directions of those reforms was to transform post-soviet style institutional-based care into more community-based services.

This paper looks at policy development process around mental health in Georgia and documents and analyses its key directions. One of the key aims of mental health reforms in Georgia was to support deinstitutionalization process. The key objectives of the strategy and policy development work to drive these reforms were to:

- construct integrated chain of needs-based services
- improve quality of life of mentally ill people
- reduce stigma and protect human rights of mentally ill people

This study concluded that the mental health policy and strategy development process in Georgia has been grounded on the best international practice and evidence. The strategic document that has been developed ensures the implementation of the deinstitutionalization process and future re-arrangement of the mental health system into a universal, flexible, equitable accessible, and sustainable model. The new model also respects the right to participate in decision-making, human dignity, nondiscrimination, transparency and accountability, and aims at promoting high standards of care and treatment and fair distribution of financial burden.

Key words: Deinstitutionalization, mental health services, community based services, strategy and action plan, reform.

Introduction

According to Global Burden of Diseases study, mental and substance use disorders are the leading cause of years lived with disability (YLD) worldwide[1], and constitute a heavy burden on individuals with the condition and their families and entire community. Stigma and discrimination associated with mental health problems aggravate the situation even further to results in diminished quality of life and negative outcomes in education, employment, income, access to adequate treatment, interpersonal relationships and social inclusion. No other health problems have a comparable diminishing socio-economic impact as mental illnesses does on the on the lives of people[2].

Nowadays, we know that it is possible to improve mental health, get better care and treatment. Moreover, there are effective intervention strategies for the prevention of mental disorders[3].

Centuries of history of mental health care have offered myriad of treatment and care approaches; among which, community-based mental health services provided a breakthrough approach to care and treatment. According to the World Health Organization (WHO), community-based mental health services deliver significantly improved treatment outcomes (e.g. as expressed in improved quality of life), contribute to the protection of human rights and are more efficient[4] than institutional care (particularly in large psychiatric hospitals). Many European countries are expidately moving from hospital-based approaches to mental health treatment to community-based approaches, where care to a person with mental disorder is provided near the place of residence. Number of studies has demonstrated that reorganization of psychiatric care and achievement of reasonable balance between hospital and community care, will deliver significantly improved results in mental health and, therefore, is recommended to all countries regardless to their economic development status (Thornicroft G, Tansella M (2003)[5].

Over the last 30 years, in Western Europe in particular, individuals have been transferred to other settings such as general hospitals or various forms of community based supported living establishments, or have been returned to their family homes[6]. This process of deinstitutionalization constitutes a new mental healthcare system.

However, some of the European countries and former socialist countries in particular, are still facing the decision to forgo unjustified large institutional mental health care for the benefit of community-based services. In these countries, mental health system is mainly constituted from large psychiatric institutions where living conditions are poor and which mostly serve the purpose to isolate patients from society, rather than to treat. Furthermore, those institutions provide lower human rights guarantees[7].

Moreover, funding model of psychiatric hospitals employed in many of the former socialist countries provides reimbursement based on the length of the occupied bed-days in hospital, and therefore, lacks incentives to either shorten the stay, or develop other forms of mental health care, such as community-based care[8].

Current status of evidence suggests that neither hospital-based care, nor community-based care can separately deliver satisfactory and comprehensive psychiatric assistance. Professional experience and research indicate that "Balanced Care Approach", which is essentially a pragmatic mix of community based and hospital based services, has the best potential to reach desired outcomes. This model ensures that[9]:

- Treatment and care, including acute treatment in general hospital and long-term care in long-term residential houses, is provided close to home (in the community);
- Manifestation of disabilities, as well as other symptoms is mitigated;
- Each patients receives treatment and care, which is appropriate for his/her specific needs;
- Human rights are protected in line with international conventions;
- Recognize the priorities of the consumers of above services;
- Mental health professionals and institutions act in coordination;
- Services are mobile, rather than static.

Number of studies has been conducted to estimate cost-effectiveness studies deinstitutionalization and community mental health services (Thornicroft G, Tansella M (2003). They have demonstrated that, although, the cost of community-based services is usually comparable to inpatient care, they generally dominated in terms of improved quality of life for people with mental disorders[10].

In terms of reforming mental healthcare system, health care experts recommend stepwise development of community-based services[11], where country's resources and development level, as well as its uniqueness and specificities are given thorough consideration.

Base on this recommendation on mental healthcare reform, Georgia had leveraged existing resources to reorganize and strengthen primary care services, day centers, community based mental health mobile teams, acute inpatient units in general hospitals, protected living and "protected employment". To guide these processes, the Ministry of Labour, Health and Social Affairs of Georgia created an action plan for development of mental health care, herein after referred as the National Strategy and Action Plan.

The development of the National Strategy and Action Plan was preceded by the assessment of the existing situation in the mental health field. The development process involved multiple

stakeholders, who were engaged in working groups created to work on each direction in the field. These directions were: out hospital service delivery, inpatient service delivery, human resource development, legislation analyze and problem solving, state and policy management. Those groups received all the information (statistical, situation analysis and recommendations by international experts on mental health development in the country) from the Ministry to use for future planning. Since the most of stakeholders involved in the working groups had commercial interests in this field, in order to avoid conflict of interest, the draft document prepared by the working groups, was reviewed by renowned international experts in the field, per the request of the Ministry of Labour, Health and Social Affairs of Georgia.

At a joint stakeholder meeting in June, 2014, the commented version of the document was presented and discussed. Furthermore, with the assistance of a Foundation "Global Initiative on Psychiatry – GIP Tbilisi" another workshop was held in July to discuss comments and recommendations. In this context, the document was restructured and once again, reviewed by the experts. By the end of 2014, the document was presented to Government of Georgia for approval. As the result of those processes the final document – Mental Health Strategy and Action plan for Georgia 2015-2020, was adopted by the Government of Georgia in December 2014.

As Coordinator of mental health reforms within the Ministry Labour, Health and Social Affairs of Georgia, I was responsible for coordination of those processes, as well as redrafting the document and incorporation of experts' recommendations.

Based on the above, the present document was developed on the basis of Mental Health Strategy and Action Plan and represents the strategy and an action plan for deinstitutionalization of mentally ill in Georgia.

Existing situation

International experience

Mental health is an integral part of health and well-being, as reflected in the definition of health in the Constitution of the World Health Organization: "Health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity". Mental health, like other aspects of health, can be affected by a range of socioeconomic factors that need to be addressed through comprehensive strategies for promotion, prevention, treatment and recovery with a whole-of-government approach[12].

Mental health is also one of the priorities of public health. It represents a major challenge for many countries of the world. People with mental disorders experience disproportionately higher rates of disability and mortality. For example, persons with major depression and schizophrenia have a 40% to 60% greater chance of dying prematurely that the general population, owing to physical health problems that are often left unattended (such as cancers, cardiovascular diseases, diabetes and HIV infection) and suicide. Suicide is the second most common cause of death among young people worldwide[13]. Worldwide, 12% of total disability adjusted life years lost (DALYs) is caused by mental and behavioral disorders, which exceeds the global burden caused by cardiovascular conditions (9.7%) and malignant tumors (5.1%)[14]. In terms of mortality, the contribution of these conditions to the lost years of life is 8.1%, while the contribution of respiratory diseases is 9%, of all types of tumors – 5.8%, of cardiac diseases – 4.4%[15].

In terms of frequency, mental diseases are quite widely spread. Mental health disorders are highly prevalent. Survey of more than 60 000 adults in 40 countries of the world in 2003-2004 has demonstrated that prevalence of all mental disorders varies between 9.1%-16.1% in majority of the countries[16].

Unfortunately, health systems, in its current state, do not provide adequately response to the burden of mental disorders. Consequently, the gap between the need for treatment and its provision is large all over the world. This gap is even more striking in low and middle-income countries, where 76-85% of people with severe mental disorders do not receive treatment for their disorder. The corresponding figures for high-income countries range from 35% to 50%[17].

Despite the fact that mental disorders have devastating effect on the quality of life of patients and their families, low and middle-income countries, on average, spend as little as less than 2% of total national health care budget on mental health.

In developed European countries, public expenditure on mental health is 8-12% of total public healthcare expenditures. Per capita expenditure on mental health was $2.7 (PPP) in Georgia in

2011, while the same indicator was $4 (PPP) in neighboring Armenia, $6.4 (PPP) in Moldova, $60.2 (PPP) in Estonia (>$100 (PPP) in developed countries)[18].

In foreign countries, mental health care is primary financed through general taxes and social insurance. The role of private insurance is limited, especially in low and middle-income countries. On average, 17.8% of total mental health expenditures are private, out-of-pocket expenditures. In low income countries, out-of-pocket spending on mental health accounts for 11% (to which Georgia belongs) of total mental health spending. In case of Georgia, where out-of-pocket expenditures predominate in total healthcare expenditures and account for 70-75% of total healthcare expenditures, out-of pocket expenditures for mental health is estimated to be as high as 40%[19].

Despite decades of deinstitutionalization and community-based care promotion, psychiatric hospitals (defined here as specialized hospital-based facilities that provide inpatient care and long-stay residential services for people with severe mental disorders) continue to consume the largest share of mental health budgets. Median expenditures on psychiatric hospitals, expressed as a percentage of total mental health spending, are greatest in upper-middle income countries (median of 74%), low-income countries (median of 73%), and lower-middle income countries (median of 73%). Expenditures are also sizeable (median of 54%) in high-income countries[20].

Currently, developed countries tend to shift towards construction of integrated chain of needs-based services, which will provide differentiated service to persons with mental health problems and their family members. The conceptual framework for this reform is represented by the novel approach – "Balanced care for mental health" – which implies provision of high quality, sustainable, cost-effective and efficacious services, appropriate for the requirements of mental health maintenance and improvement, considering the needs of population and resources of the country. This approach does not reject one model (e.g. hospital treatment) in favor of another (e.g. community based service), but rather encourages combination of all possible and necessary forms to maximize outcomes.

WHO's Mental Health Action Plan for 2013-2020 proposes that countries shift from long-stay mental hospitals to community-based settings and develop a network of linked community-based mental health services, including: short-stay inpatient care and outpatient care in general hospitals, primary and other non-specialized health care, comprehensive mental health centers, day care centers, supportive services of people with mental disorders living with their families, and supported housing[21].

Deinstitutionalization is an essential part of the reform of mental health services. This does not only mean discharging people from long-stay hospitals. It requires significant changes involving

development of community-based alternative services, rather than institutions for the delivery of services. The provision of services in the community should go hand-in-hand with reduction of populations in psychiatric hospitals. Deinstitutionalization should proceed in stages once community-based alternatives are in place. Achievement of desired results requires strong commitment among planners, managers and clinicians[22].

Mental Health Care in Georgia

Medical statistics

Neuropsychiatric diseases represent 22.8% of burden of diseases in Georgia[23].

According to the official data on mental health in Georgia, in 2013:

- In out-patient clinics diagnosed and registered 68 922 cases of mental and behavioral disorders, out of which, there were 3020 were diagnosed first time during the lifetime.
- Prevalence of mental disorders was 1743.5 per 100 000 population, and incidence was 90.7 cases per 100 000 population (Table 1)[24].

Distribution of mental and behavioral disorders according to nosology, Georgia, 2013

	New cases	Cases by the end of the year	Incidence per 100000 population	Prevalence per 100000 population
Total	**3020**	**68922**	**67.3**	**1536.0**
Disorders of Organic nature, including symptomatic disorders	**595**	**10153**	**13.3**	**226.3**
Mental and behavioral disorders due to psychoactive substance use	3	2033	0.1	45.3
Schizophrenia, schizotypal and delusional disorders	**933**	**21292**	**20.8**	**474.5**
Persistent mood [affective] disorders	273	4702	6.1	104.8
Neurotic, stress-related and somatoform disorders	221	6829	4.9	152.2
Behavioral syndromes associated with physiological disturbances and physical factors	4	428	0.1	9.5
Disorders of adult personality and behavior	42	3680	0.9	82.0
Mental retardation	603	19109	13.4	425.9
Disorders of psychological development	223	254	5.0	5.7
Behavioral and emotional disorders with onset usually occurring in childhood and adolescence	123	442	2.7	9.9

According to the 2013 data, psychiatric hospitals discharged 2851 patients and there were 32 cases of death (mortality rate 1.1%) (Table 2)[25].

Table 2

Mental and behavioral disorders, inpatient service, Georgia 2013			
	Discharged from hospital	**Including dead**	**Mortality rate (%)**
mental and behavioral disorders	**2851**	**32**	**1.1**
including			
Disorders of Organic nature, including symptomatic disorders	418	7	1.7
Mental and behavioral disorders due to psychoactive substance use	4	0	0
Schizophrenia, schizotypal and delusional disorders	2017	21	1.0
Among them: schizophrenia	1451	17	1.2
Persistent mood [affective] disorders	201	0	0.0
Neurotic, stress-related and somatoform disorders	33	0	0
Behavioral syndromes associated with physiological disturbances and physical factors	0	0	0
Disorders of adult personality and behavior	47	0	0
Mental retardation	121	4	3.3

According to the assessment of independent experts, this information is incomplete[26]. Prevalence of mental disorders is at least twice as high compared to the official data: "schizophrenia morbidity rate is 20-54 per 100 000 population in the most of the countries of the world, while it is only 9.5 in Georgia".

This situation is due to several reasons:

Deficiencies of the official statistical data collection system: Official figures are based on referral rates in psychiatric institutions, which record only the cases undergoing treatment, but not an actual prevalence of the diseases.

Flaws with the reporting system: During the Soviet period registration of mental disorders was compulsory and was strictly regulated. According to the Law of "Psychiatric care", which was adopted in 1995, the patients are free to refuse registration, if they want so. Currently, the registration system is linked to psychiatric out-patient services funded under the State Program on Mental Health. This regulation implies that if person registers, the treatment will be provided for free. This creates two major issues: firstly, patients who choose not to register, can continue treatment on private payment terms and will be lost for the reporting system (or if

they won't start treatment at all), and secondly, as the State Program does not cover all mental health diagnosis, sometimes patient's diagnosis can be aggravated, in order for the patient to get free treatment. For example, mild depression can be formalized as a serious depressive disorder, because the former diagnosis is not funded by the state program. It should be also noted that in the psychiatric hospitals despite the fact, that in hospital services are funded by the state program, registration system did not

function, the patient may be admitted in psychiatric hospital several times, and its data will not be reflected in the statistics, because they do not have the obligation of registering.

Low referral rate to mental health professionals: Due to various factors, such as stigma, lack of knowledge and others, very often, people with mental illness do not get referred to psychiatrists. They either resort to self-treatment, or seek care (often inappropriate) from other specialists, such as neurologists and psychologists.
This shows that only a small proportion of individuals who need mental health care, actually receive appropriate services.

Mental Health Delivery System in the Country

Healthcare infrastructure

Most of the facilities that provide mental health services are also registered providers of the State Program on Mental Health (register provider means that the services they provide are reimbursed by the state and are free for patients). In total there are 24 medical facilities, which are providing mental health services within the mental health state program. There are four in-patient treatment facilities, while nine facilities have out-patient services (including, out-patient services at some of the in-patient facilities). Three out-patient care centers also provide crisis intervention. There is only one facility, which provides out-patient psycho-social rehabilitation and one facility, which provides care for children, limited to diagnostic services (Table 3).

There are some private healthcare clinics that are not registered with the State Program. Those include one private mental health clinic in Tbilisi, which has very low level of utilization, as the services are quite pricy and several non-governmental organizations that provide various services for people with mental disorders as a part of some donor funding.

Table 3

	Facilities registered with mental health state program		
N	Name of the facility	Services	Type of the facility
1	LTD "Tbilisi Mental Health center"	Outpatient Inpatient	Specialized psychiatric facility, publicly owned
2	LTD "Center of Mental Health and Prevention of Addiction"	Outpatient Crisis Intervention Inpatient	Specialized psychiatric facility, publicly owned
3	LTD "Sunstone Medical"	Inpatient	General Hospital Unit, privately owned
4	LTD "Abkhazia Psychoneurological Dispensary"	Outpatient	Specialized psychiatric facility, publicly owned
5	LTD "N5 Clinical Hospital"	Inpatient Inpatient for children	General Hospital Unit, privately owned
6	LTD "Academican O. gudushauri National Medical Center"	Inpatient	General Hospital Unit, privately owned
7	LTD "Republic Clinical Psychological Hospital"	Outpatient Crisis Intervention Inpatient	Specialized psychiatric facility, publicly owned
8	Lanchkhuti Psychoneurological Dispensary LTD "Nevroni"	Outpatient	Specialized psychiatric facility, publicly owned
9	LTD "Kutaisi Mental Health Center"	Outpatient Crisis Intervention Inpatient	Specialized psychiatric facility, publicly owned
10	LTD "The National Center of mental Health of Acad. Bidzina Naneishvili"	Outpatient Inpatient (including Forensic Psychiatry)	Specialized psychiatric facility, publicly owned
11	LTD "Senaki Interregional Psychoneurological Clinic"	Outpatient Inpatient	Specialized psychiatric facility, publicly owned
12	LTD "A. Kajaia Surami Psychiatric Hospital"	Outpatient Inpatient	Specialized psychiatric facility, publicly owned
13	LTD "Rustavi Mental Health Centre"	Outpatient Crisis Intervention Inpatient	Specialized psychiatric facility, publicly owned
14	LTD "Bediani Psychiatric Hospital"	Inpatient	Specialized psychiatric facility, publicly owned
15	LTD "Medalfa"	Outpatient	Office in a general health care facility, privately owned
16	LTD "Geohospitals"	Outpatient	Office in a general health care facility, privately owned
17	LTD "Telavi Psychoneurological Dispensary"	Outpatient	Specialized psychiatric facility, publicly owned

18	LTD "Archimedes Clinic"	Outpatient	Office in a general health care facility, privately owned
19	LTD "Mtskheta Primary Health Care Center Healthy Generation"	Outpatient	Office in a general health care facility, privately owned
20	LTD "Zugdidi Interregional Psychonarcological Dispensary"	Outpatient	Specialized psychiatric facility, publicly owned
21	LTD "Unimedi-Samtskhe"	Outpatient	Office in a general health care facility, privately owned
22	LTD "Gormed"	Outpatient	Office in a general health care facility, privately owned

A study conducted in 2008, confirmed that treatment and support services for people with mental disorders in Georgia is insufficient and ineffective[27].This study identified some of the causes as well:

- Limited affordability and accessibility of services;
- Low quality and efficiency of available services;
- Depreciated and inefficient infrastructure in large institutions;
- Extremely limited number of social integration services.

In 2010 the Ministry of Labour, Health and Social Affairs of Georgia started reforming mental health system. As a part of those reforms, major rehabilitation/reconstruction of mental health infrastructure was undertaken. In the capital city of Tbilisi, mental health departments in three multi-profile hospitals and one specialized clinic were rehabilitated, and in regions, three specialized clinics were rehabilitated. As a result of this reform, a large and depreciated psychiatric hospital in Tbilisi was closed down. It served about 225-250 patients and after closing down, those patients were distributed to newly rehabilitated facilities as described in the Table 4.

Instead of one large psychiatric institution, following facilities were designed and rehabilitated:

- Tbilisi, LTD "Center of Mental Health and Prevention of Addiction":
    - Outpatient service;
    - Crisis interventions service, including home care services;
    - 80-bed department for inpatient service;
- Tbilisi, LTD “Sunstone Medical”:
    - 30-bed department for inpatient service;

- Tbilisi, LTD "Academician O. Gudushauri National Medical Center":
    - 30-bed department for inpatient service;
- Tbilisi, LTD "N5 Clinical Hospital":
    - 30-bed department for inpatient service;
    - 10-bed department for inpatient service for children;
- Kutaisi, LTD "Kutaisi mental health center":
    - Outpatient service;
    - Crisis interventions service, including home care services;
    - 30-bed department for inpatient service;
- Batumi, LTD "Republic Clinical Psychological Hospital":
    - Outpatient service;
    - Crisis interventions service, including home care services;
    - 30-bed department for inpatient service;
- Rustavi, LTD ""Rustavi mental health center":
    - Outpatient service;
    - Crisis interventions service, including home care services;
    - 22-bed department for inpatient service;

Table 4

Infrastructure before reform process		**Infrastructure after reform process**	
Name of the hospital	**Number of beds**	**Name of the hospital**	**Number of beds**
Tbilisi, LTD "M. Asatiani Research Institute of Psychiatry"	225	Tbilisi, LTD "Center of Mental Health and Prevention of Addiction"	80
		Tbilisi, LTD "Sunstone Medical"	30
		Tbilisi, LTD "Academician O. Gudushauri National Medical Center"	30
		Tbilisi, LTD "N5 Clinical Hospital"	40
		Rustavi, LTD "Rustavi mental health center"	22
		Batumi, LTD "Republic Clinical Psychological Hospital"	30
		Kutaisi, LTD "Kutaisi mental health center"	30

This reform has resulted in significant innovations in number of aspects of mental health care in the country. Namely:

- Integration of psychiatric departments in general, multi-profile hospitals;
- Creation of the children's inpatient department (this department did not exist in Georgia and inpatient service for children was not provided over the years);
- Rehabilitation of infrastructure, which allows patients to receive, needed medical service in acceptable living condition.

Despite these infrastructural changes, issues and problems in mental health field still remain. The state needs to develop management system of the care and treatment and formulate a vision for the development of the system.

Hospital sector

Starting from the end of the 80's, the number of psychiatric beds substantially decreased in Georgia, like in other post-soviet countries. According to WHO, in 2011 number of patient beds in specialized psychiatric hospitals was 3.09 per 10 000 population in high-income countries, but it was 2.86/10 000 in Georgia. There is a significant difference between Georgian and Europe in terms of number of community-based services and number of beds integrated in the community. For example, in Europe, the number of beds integrated in general hospitals is 1.36 per 10 000 population, while in Georgia it is 0.22 per 10 000 population. Provision of community residential care facilities is 1.015 per 10 000 population in high-income countries, while in Georgia this type of service is not available at all. Number of beds in Day Centers and other community services is the highest in EU countries and equals to 4.3 per 10 000 population, while in Georgia this is 0.1 per 10 000 population[28,29].

According to the World Health Statistics yearbook for 2012, Georgia has 2.9 psychiatric beds per 10 000 population, while the average figure in Europe is 6.3 beds per 10 000 population[30]. The data shows that the Georgia is far from European average indicators of mental health service provision, especially, in terms of hospital care and number of psychiatric beds available in the country is very low, especially, if we considered that community-based services are also very limited.

According to the report of the Ombudsman of Georgia[31] and CoE 2013 survey[32], practices of human rights violations are still widespread in specialized psychiatric hospitals of Georgia. Unfortunately, these institutions often do not meet the quality standards for treatment and care.

In the institutions, where psychiatric beds are placed nowadays (Table 5), physical infrastructure and conditions for the patients are not inhomogeneous. According to the recommendation of the Council of Europe, living conditions of psychiatric patients should be as close as possible to normal family conditions[33]. Infrastructure in the old buildings do not meet those requirements, as it is outdated and bathrooms, patient's rooms, staff rooms and furniture

are damaged. All of these creates significant inconvenience both for patients and staff and require immediate intervention to ensure proper – dignifying and rightful -- environment for treatment and working conditions for the staff. In some of those old hospitals adequate heating is not provided and hot water supply is limited.

Moreover, the most of those facilities still apply old-fashioned treatment methods and practices[34]. This is also a subject of serious criticism from various organizations, including international organizations and is reflected in number of reports and studies. Apart from the fact that infrastructure in mental health hospitals is impaired, the old buildings are also located away from patient's home and their family and they provide only medicated treatment for persons with mental disorders. During the last visit of the European Committee for the Prevention of Torture, which took place in December 1-11, 2014, the assessment team looked at one of the largest psychiatric facility in Georgia and their conclusion was that the design of the hospital is completely incompatible with the practice of modern psychiatry and sanitation system is damaged.

Currently, there are two major challenges of mental health hospital sector in Georgia:

1. With the development of community-based services, creation of the community-based psychiatric beds;
2. Development/transformation of psychiatric beds in the country that involves rehabilitation of existing infrastructure and implementation of new methods of treatment and psycho-social interventions.

Table 5

Distribution of psychiatric beds in 2013					
Name of the facility	**Number of beds**				
	Total	**Children**	**General hospital**	**Other – crisis intervention/dispensaries**	**Psychiatric institutions**
LTD "Tbilisi Mental Health center"	220				220
LTD "Center of Mental Health and Prevention of Addiction"	88			8	80
LTD "The National Center of mental Health of Acad. Bidzina Naneishvili"	650				650
LTD "A. Kajaia Surami Psychiatric Hospital"	90				90

LTD "Bediani Psychiatric Hospital"	120				120
LTD "Republic Clinical Psychological Hospital"	154			4	150
LTD "Kutaisi Mental Health Center"	34			4	30
LTD "Senaki Interregional Psychoneurological Clinic"	15				15
LTD "Academican O. Gudushauri National Medical Center"	30		30		
LTD "N5 Clinical Hospital"	40	10	40		
LTD "Sunstone Medical"	30		30		
LTD "Rustavi Mental Health Centre"	26			4	22
Total number of beds	**1497**	**10**	**100**	**20**	**1377**

Funding of hospital services in Georgia is provided by the State Program on Mental Health. This program provides reimbursement for the following conditions and with the following terms:

- Acute in-patient services are reimbursed on fee for service bases, but with a limit of 840 GEL per case; and
- Long-term in-patient services are reimbursed with 450 GEL, which is for one month of a treatment.

This financing model gives incentives to hospitals to admit as many patients as possible and discharge acute patients as soon as possible, while prolong the length of stay for long-term treatment. Therefore, hospitals lack incentives to develop outpatient services, or provide such care to their beneficiaries. In addition, there are cases when the patient is discharged from the hospital in a severely untreated condition, due to the exhaustion of per case limit (840 GEL per case) and he/she gets re-admitted within short period of time, so that facility can continue treatment with a new case limit.

Detailed analysis of charges and utilization of in-patient services under the State Program on Mental Health shows that most of the patients are re-hospitalized several times during the year, in some cases every month. In particular, in 2014, total 4 196 individuals received services, but 873 of them (20% of the total number of beneficiaries) were re-hospitalized. Out of re-hospitalized patients, 412 individuals (47% of the total number of re-hospitalized patients) were re-hospitalized severe cases and accounted as 1 118 cases (26% of the total number of re-hospitalization), and 461 patients (53% of the total number of re-hospitalized patients) were re-hospitalized as acute, as well as a long-term care beneficiaries and the total number of cases registered 3 186 (74% of the total number of re-hospitalization).

Lack of community-based housing service creates major problem and artificially increases hospitalization rates. 32% of beneficiaries admitted to the hospitals are basically homeless (either they do not have a housing, or their family members do not allow them to stay with

them). Therefore, their discharge is quite complicated and often unsuccessful, as they do not have anywhere to go.

Outpatient services

Out-patient mental healthcare in Georgia is either provided by service providers registered with the State Program on Mental Health or centers funded by international donors. Specifically, the State Program funds psycho-neurological dispensaries, offices in general medical facilities, crisis intervention centers and one psycho-social rehabilitation center.

Psycho-neurological dispensaries and the offices in general medical facilities are geographically spread around the country, but only partially ensure affordability and accessibility for service for the whole population. Problems with outpatient mental health centers negatively impact on the quality of care and treatment.

Outpatient services are mainly carried out by 18 medical facilities (including psychiatric dispensaries, mental health centers and offices/departments in primary health care centers), which are scattered around the country. However, most of them are located in the big cities. The current outpatient psychiatric services are mainly focused on the doctor's consultations and medication delivery. Selection and the quality of the medication delivered by outpatient services do not meet the needs of patients discharged from the hospital. This makes it difficult to maintain clinical results achieved as a result of hospital care.

Out-patient care in Georgia is not delivered by multidisciplinary teams, since there is lack of relevant human resources, as well as funding. Therefore, bio-psycho-social approach is not in place. Services are mainly limited to consultation by a psychiatrist, who does not have enough knowledge and time to provide appropriate psychosocial interventions. As a rule, doctors follow traditional medical model: counseling and medication delivery. One psychiatrist receives about 300-500 patients in a month and this workload prevents them to allocate more time for doctor-patient relationship. The shortage of community-based services is high. There are only three psycho-social rehabilitation centers in the country and they receive little funding from the state budget (less than 1% of total budget of state program). It is impossible in the current situation, as delivery necessary service, as well as the development of new service centers, as well as introduction/transfer of psychosocial interventions, which are established in the psycho-social rehabilitation centers, in all state funded outpatient facilities.

There are few crisis interventions centers are integrated in traditional inpatient and outpatient care network; however, they do not cover the whole territory. Moreover, crisis intervention services, including outpatient crisis beds do not operate 24hours. Addition issue with crisis intervention services is their location. As this service was only recently introduce, there was a

large mistake made from the very beginning to locate the centers with the mental health hospitals, as this stigmatized this new service as well. Due to their location, crisis intervention centers do longer serve any gate-keeping function.

There is only one assertive community service team working in Georgia with the funding of a donor organization. This team is located in Tbilisi. It is the only multidisciplinary team, which provides assertive mobile service for patients with severe chronic mental disorders.

There are no community housing facilities or employment support system for mentally ill people in Georgia.

Hence, within the outpatient service, the risk of aggravation and re-hospitalization is high.

One of the reasons is lack of funding. Funding for outpatient services is relatively small compared to in-patient services. In 2014, out-patient care received only 19% (2 865 300 GEL) of total public funds allocated for mental healthcare in the country, while inpatient services received 69% (10 421 880 GEL) of this amount.

Additional problem is how out-patient services are funded. Outpatient services are funded with a global budget and budgetary allocations have not changed since 2010, while number of patients had increased approximately by 30%. Also does not function coverage zones and it is unclear on what is based the volume of the budget for each mental health facility (calculated limits are following the state program historically since 2007) (see Table 6).

In addition, infrastructure allocated for outpatient psychiatric services has diminished during the last few years. Some of those facilities were integrated into other institutions and now have less space (for example: in Gori, Samtredia, Akhaltsikhe, Tbilisi, Sighnaghi). In some cases, outpatient mental health centers (dispensaries) were transformed into the offices in health care centers. This fact represents one of the obstacles for the implementation of new and modern forms of mental health outpatient services.

As for the number of beneficiaries, over the years, registration of beneficiaries were carried out based on the free choice of a patient to register, or not and one and the same patient could be registered with several facilities. This has led to increase the number of beneficiaries. To eliminate this problem, the Ministry of Labour, Health and Social Affairs designed electronic outpatient registration module for beneficiaries. Now it is possible to obtain information about the total number of beneficiaries and eliminate duplicated registrations in different facilities.

Furthermore, primary health care is not engaged in mental healthcare delivery -- detection, prevention and management of the persons with mental disorders. Besides lack of time of primary health care staff, they have no knowledge and competence how to detect, manage and refer patients in acute condition.

Table 6

N	Name of the facility	N	Name of the facility	Number of registered beneficiaries	State program budget for month (GEL)
1	LTD "Tbilisi Mental Health center"	1	LTD "Tbilisi Mental Health center"	2 095	12 230
2	Ltd. "A. Gotsiridze State Tbilisi Psycho-Neurological Dispensary"	2	LTD "Center of Mental Health and Prevention of Addiction"	6 656	52 318
3	LTD “M. Asatiani Research Institute of Psychiatry”				
4	LTD "Abkhazia Psychoneurological Dispensary"	3	LTD "Abkhazia Psychoneurological Dispensary"	483	3 396
5	LTD "Republic Clinical Psychological Hospital"	4	LTD "Republic Clinical Psychological Hospital"	1 974	16 518
6	LTD "Ozurgeti Psychoneurological Dispensary"	5	LTD "Medalfa"	1 315	6 533
7	Lanchkhuti Psychoneurological Dispensary LTD "Nevroni"	6	Lanchkhuti Psychoneurological Dispensary LTD "Nevroni"	1 028	7 077
8	LTD "Kutaisi Iv. Skhilrtladze State Psycho-Neurological Dispensary"	7	LTD "Kutaisi Mental Health Center"	3 875	27 663
9	Zestafoni LTD "Psychiatrist-Narcologist"	8	LTD "Geohospitals"	910	15 419
10	Samtredia LTD "Psychiatry"				
11	LTD "The National Center of mental Health of Acad. Bidzina Naneishvili"	9	LTD "The National Center of mental Health of Acad. Bidzina Naneishvili"	257	2 267
12	LTD "Telavi Psychoneurological Dispensary"	10	LTD "Telavi Psychoneurological Dispensary"	2 625	9 994
13	Sighnaghi Neurological Dispensary LTD	11	LTD "Archimedes Clinic"	1 332	9 994

	"Psychonevrology"				
14	LTD "Mtskheta Primary Health Care Center Healthy Generation"	12	LTD "Mtskheta Primary Health Care Center Healthy Generation"	715	5 124
15	LTD "Zugdidi Interregional Psychonarcological Dispensary"	13	LTD "Zugdidi Interregional Psychonarcological Dispensary"	1 627	13 160
16	LTD "Senaki Interregional Psychoneurological Clinic"	14	LTD "Senaki Interregional Psychoneurological Clinic"	3 184	16 084
17	LTD Akhaltsikhe Interregional Psycho-Neurological Dispensary	15	LTD "Unimedi-Samtskhe"	1 020	7 001
18	LTD "Rustavi Mental Health Centre"	16	LTD "Rustavi Mental Health Centre"	3 069	20 581
19	Gori Neurological Dispensary LTD "Psikia"	17	LTD "Gormed"	2 067	8 720
20	LTD "A. Kajaia Surami Psychiatric Hospital"	18	LTD "A. Kajaia Surami Psychiatric Hospital"	609	4 695

Future vision

Based on the problems in the mental health field identified above, the relevant strategic priorities have been developed.

Mental health policy document was approved by the Parliament of Georgia in December 2013. This document was developed with the participation of representatives of different structures, non-governmental organizations and donor organizations. Mental Health Strategy and Action Plan for 2015-2020 was developed based on this policy and adopted by the Government of Georgia in December 2014. The main topic of this Action Plan is deinstitutionalization of persons with mental disabilities and it provides list of activities/steps to achieve this through balanced approach between in-patients and community-based services.

Georgia has to reject unjustified institutional psychiatric care in hospitals with poor conditions, which serve more isolation purpose, rather than treatment and do not provide guarantees of human rights. It should also be noted that the reduction of psychiatric beds is not a reform process itself, as it was understood at the end of the 80's, when the number of psychiatric beds were substantially decreased in Georgia, but there was no development of community-based services. After this, so called, reform, majority of patients, who were discharged from hospitals, remained without proper care and supervision.

The main goal of strategic planning of deinstitutionalization is to improve mental well-being of the population, prevent mental disorders, protect the rights of persons with mental disorders and increase their re-socialization, and, finally, reduce morbidity and disability caused by mental disorders. Development of out-of-hospital services should go in parallel with deinstitutionalization process, so that individuals with mental disorders can access continuing medical care after an acute episode, psychological and social rehabilitation services, vocation skills development, employment and other services at their communities. This should mean that a person with mental disorder will receive service in his/her community, while if acute episodes happen, he/she will be placed in a general hospital, not in a large psychiatric hospital and hospitalization time will be short and patient will be discharged without delay, but after receiving appropriate treatment.

This approach calls for regularly needs assessments of people with mental disorders and analysis of the existing services. Any reforms/decision regarding the system should be based on this information and resources availability (financial capacity, quality of personnel training) and should ensure balance between hospital treatment and community based mental health services.

That is why the future vision of mental health care is based on the following values:

- Respect for humanity and human dignity;
- Equality and access;
- Tolerance.

Future vision of deinstitutionalization of mental health care is based on the following approaches and principles:

- "Balanced treatment", which means securing a balance between hospital and community-based care, medical and non-medical treatment, individual, community and family interests, prevention, treatment and rehabilitation services.
- "Integration", which includes integration and continuity of care, integration of health and social services, social inclusion and participation instead of isolation.
- "Consistency" – evolutionary and harmonious development.

The future arrangement of deinstitutionalization of persons with mental disorders will satisfy the following requirements: flexibility, sustainability, reduced stigmatization, oriented on needs and result, high standards of care and treatment and a fair distribution of financial burden.

The following activities and services should be in place before patients are transferred from hospitals to communities:

1) Mental health services should be available in primary care facilities. This requires training of family doctors, nurses and other primary care workers in identification and treatment of mental disorders;
2) Beds, facilities and specialist staff should be provided in general hospitals or in the community for the management of acute relapses requiring short-term hospitalization;
3) Staff in existing mental hospitals should be retrained to take up positions in general health care settings, including the supervision of primary care staff and the provision of mental health services in general hospitals;
4) Psychotropic medication should be available in primary care and general hospital settings;
5) Formal and informal community mental health services should be introduced in order to help with community rehabilitation[35].

To achieve these goals the following priorities and activities have been identified:

1. Improvement of coordination in mental health
2. Integration of mental health care in primary health care system
3. Restructurization of existing outpatient mental health service into the community-based services
4. Restructurization of existing hospital beds
5. Mental health support and mental health prevention
6. Public awareness rising

7. Development of quality monitoring system.

Strategic priority 1 – Improving coordination in mental health

Planning and organization of mental health system is quite a complex process and requires engagement of various stakeholders, including different governmental structures and administrative levels. The exclusive prerogative of the government is a management of mental health system and mental health services. Furthermore, the government plays the key role in financing the mental health services and provision of high quality services to the vulnerable population. State agencies are responsible to develop legislation in coordination with other stakeholders and then engage in regulating the system in accordance with the existing legislative framework.

Monitoring and evaluation of the process and outcomes of mental health policy implementation is an essential part of the policy development and implementation process. It allowed the government to timely intervene in the reformation process and make corrections, where appropriate. Proper monitoring and evaluation requires establishment of a unified system of assessment, formulation of assessment indicators, targets, data collection frequency, data sources and responsible structures.

Monitoring and evaluation of the process of deinstitutionalization is a complex process. For this purpose, there should be a coordination team in place to bringing together the whole range of stakeholders who have an active role and interest in improving mental health care, including: service users, family members, professionals (mental health and primary health care), non-governmental organizations, policy makers, advocacy groups, and others. After the coordination team is created, each policy priority should have working group responsibility for oversight. Furthermore, each working group should designate an individual who will take of the responsibility to report back on the progress and failures in the implementation process.

Activity 1: Creation of coordination team for monitoring and evaluation of deinstitutionalization process;

Activity 2: Formulation of working groups to work on each strategic priority and appointment of a responsible person from each group.

Strategic priority 2 – Integration of mental health care in primary health care system

Effective participation of primary healthcare professionals in patient's referral to the mental health system, when needed and further management of cases, after their referral back from specialized services, is essential to improve the quality of the mental health care. Therefore, capacity of the primary health care personnel in timely identification and management of mental health problem should be increased. Increasing access to mental health services at a primary care level will mitigate issues caused by the lack of specialized services, will improve accessibility of services and reduce stigma. However, mental health services at a primary healthcare level will require supportive supervision from mental health professionals in order to achieve sustainable integration within specialized services and be of an appropriate quality. The following activities should be planned and implemented to fulfill this strategic priority:

Activity 1: Creation of electronic database of number and geographical allocation of primary health care professionals;

Activity 2: Training of primary healthcare personnel in identification, management, referral and age-specific skills regarding mental health issues;

Activity 3: Elaboration of flexible and sustainable model of collaboration of primary health care and mental health community services;

Activity 4: Providing supportive supervision for trained primary health care professionals.

Successful implementation of these steps in every field and especially in target groups I think will be founded on the availability of the right response, at the time, with appropriate follow up. These offers hope that recognizing the link between physical health condition and mental health will become the basis of developing standard medical and mental health practice in the future.

Strategic priority 3 – Restructurization of existing outpatient mental health service into the community based services

The main priority of community-based mental health services is to provide individuals with severe mental disorders with services close to their homes. Studies and systematic reviews of inpatient versus community-based services have shown that multidisciplinary teams and community services have advantages: they can improve patients' involvement in psychiatric services, increase customer satisfaction, meet their needs and improve treatment compliance[36]. In addition, continuity of care and service flexibility is easier to achieve in a setting, where community mental health teams exists[37].

One of the prerequisites of early diagnosis and treatment of mental health problems is a sufficient access to appropriate services. Therefore, services should be planned with consideration of geographical allocation and population density, availability of qualified personnel and level of psychiatric stigma.

There is no evidence that community mental health care can completely replace in-patient care. In some cases, when people need urgent medical assessment or those with severe psychiatric conditions, they can best receive require immediate support in acute inpatient units. The following activities should be planned and implemented to fulfill this strategic priority (see Annex 1):

Activity 1: Definition of catchment areas for ambulatory and community services;

Activity 2: Development/update of standard packages for community-based multidisciplinary services (community mental health teams, day care centers, psycho-social rehabilitation services);

Activity 3: Development of community mental health teams in ambulatory services, considering catchment area;

Activity 4: Development of psycho-social rehabilitation services.

Strategic priority 4 – Restructurization of existing hospital beds and creation of new ones

This strategic priority includes creation of psychiatric inpatient wards in general hospitals, and support for homeless patients through their placement in long-term community based residential facilities. Coordination and delivery of these services within geographical catchment areas can help to promote the principle of continuity of care. The following activities should be planned and implemented to fulfill this strategic priority:

Activity 1: Integration psychiatric beds for adult in general hospitals in Tbilisi and regions;

Activity 2: Creation of psychiatric beds for adolescents and children in general hospitals in Tbilisi and regions;

Activity 3: Establishment community residential facilities (see Annex 2 and Annex 3).

Strategic priority 5 – mental health support and mental disorder prevention

Mental disorders are highly prevalent. They are associated with high degree of disability and affect significant portion of population, while access to needed treatment is limited. Any policies

in this field should be based on sound information on mental health epidemiology, severity of those disorders, their impact in terms of disability and social and economic costs.

This information should be used by policy makers while designing mental health promotion and mental disorders prevention programs. Prevention, treatment and rehabilitation should be widely available. The prevention of mental health problems and mental disorders is based on reduction of risk factors for mental disorders and enhancement of protective factors that promote mental health.

Preventive interventions should be targeted universally to the whole population and should be aimed at improving the overall mental health of the population. Stakeholders must study the public attitudes (beliefs, attitudes, expectations) to develop and implement long and short-term strategies on public awareness raising and stigma reduction. Media has an important role to play in this process. Therefore, there should be a set of activities specifically targeted at media outlets to ensure their knowledge and awareness of issues around mental healthcare.

There are number of preventive interventions that can be targeted selectively to some subgroups of population or individuals, who are at increased of developing mental disorder, or are high-risk groups, such as those with early signs and symptoms of mental health problems and disorders. Those types of interventions are called "selective". Selective preventive interventions aim to reduce risks for the targeted population. Examples of such interventions are positive parenting programs in disadvantaged population, school-based programs specifically targeting young people at risk of depression, programs for people exposed or at risk of the following adverse life experiences, such as divorce or military conflicts, programs for children displaying the early warning signs of behavioral disorders such as aggression and noncompliance, and programs to intervene during the early signs for psychosis. Selective preventive interventions should be designed for public schools, workplaces and settlements of internally displaced persons (IDPs), for risk groups such as unemployed/disabled individuals.

In terms of mental health promotion interventions, there is a growing evidence that parenting programs and school-based and work-based programs can achieve positive mental health outcomes in terms of reduced risks and improved functional status. Supported educational programs and mental health literacy can improve population's knowledge about mental health. Promotional information for employment service staff, police, emergency service staff, teachers, local community groups, general practitioners will help to promote mental health and prevent the onset of mental disorders and/or mental health problems across the lifespan.

Goals of promotion and prevention differ from each other. Promotion activities aim to improve mental health, while preventive activities aim to prevent the development of mental health

problems and disorders. However, both of these interventions often adopt similar approaches and produce similar outcomes. Thus, a mental health promotion intervention aimed at increasing wellbeing in a community, may also have an effect on decreasing the incidence of mental health problems and mental disorders in that community.

Strategic priority 6 - Public awareness rising

Raising public awareness and changing attitudes towards persons with mental health problems is the most important aspect to increase access to the mental health services. Therefore, Georgia needs to create promotional and educational programs for families, general public, doctors and students. The society should help persons with mental disorders to lead a full life and persons with mental illness and their family members should be involved in public life, so that they do not feel themselves marginalized. Evidence-based public awareness raising interventions have a potential to considerably change attitude towards people with mental disorders[38]. The following activities should be planned and implemented to fulfilling this strategic priority:

Activity 1: Study of public attitudes (opinions, attitudes, expectation);

Activity 2: Implementation of informational and educational activities to reduce stigma;

Activity 3: Increase of awareness among mass media representatives on core issues of mental health state policy, developing training materials and conduct training.

Strategy monitoring 7 – Development of quality monitoring system

Choice of indicators (inputs, process and outcomes) for quality monitoring depends on particular service priorities in a local setting. Input indicators can be used to measure standards related to adequate staffing and availability of beds and pharmaceuticals. Process indicators can be used to measure standards related to the optimal utilization of inpatient facilities and outcome indicators can be used to measure standards related to the positive impact of interventions. During a deinstitutionalization, readmission rates may be an important indicator of the adequacy of community based care. Outcome indicators that can be used for the monitoring, include: clinical status, functioning, consumer satisfaction and quality of life. Outcome indicators are more direct measurement of quality than structure or process indicators.

Quality monitoring system does not exist in Georgian and there are no specific indicators and implementation mechanisms in place. To implement the monitoring system, it is necessary to collect data, such as:

- Quantitative data:
    - Number of beneficiaries registered in outpatient clinics;
    - Number of beneficiaries, who receive outpatient treatment;
    - Number of outpatient visits;
    - Number of beneficiaries, who receive psycho-social rehabilitation;
    - Number of acute patients admitted in hospital;
    - Average number of bed-days for acute inpatient cases;
    - Number of beneficiaries, who are admitted for long-term in hospital treatment;
    - Average number of bed-days for long-term inpatient cases;
    - Number of new cases (patients who are admitted in hospital for the first time);
- Qualitative data:
    - Geographic distribution of patients;
    - Rate of re-hospitalization in short-term (acute) in-patient unit;
    - Totally Number of re-hospitalizations;
- Expenditure data:
    - Expenditures per case;

Patient satisfaction is one of the key indicators to measure quality of care. Therefore, relevant measurement tools, such as questionnaires should be in place. They can be completed by a social worker. Monitoring and analysis of the obtained results is desirable to be carried out once in every three months and annually. Detailed information on monitoring scheme for Mental Health State Program and Patient Satisfaction Questionnaire are provided in Annex 4 and Annex 5, respectively.

Potential threats

Implementation of this policy document can be negatively influenced by a range of factors, such as:

- Insufficient funding of mental health services;
- Difficulties in effective integration of mental health in primary care;
- Fragmentation of mental health advocator teams;
- Lack of competence of human resources;
- Unforeseen radical reforms / changes in healthcare system;
- Lack of infrastructure for mental health services (residential houses, community mental health centers);
- Political and economic instability in the country.

Conclusion

Deinstitutionalization of mentally ill will positively contribute towards improvement of mental health of the population, increase of affordability and access of mental health services, raising public awareness and changes of attitudes. The main purpose of this process will provide all interested parties in accordance with the needs and interests of their own abilities and find a place to achieve maximum results of mental health care, especially in a country that still has a significant number of unmet needs regarding mental health services, delivery of care and epidemiological research. People with mental disorders of any age, gender, ethnic background or religious beliefs deserve to be treated with dignity. They should be given an equal opportunity to receive services, which are focused on the mental health needs, especially for the vulnerable groups, such as IDPs, children and elderly.

Implementation of the deinstitutionalization process and future re-arrangement of mental health system will satisfy the following principles: universality, flexibility, social equality, easy access to health services, solidarity, sustainability, right to participate in decision-making, respect for human dignity, nondiscrimination, transparency and accountability, high standards of care and treatment and fair distribution of financial burden.

Deinstitutionalization Action Plan 2016-2020

Directions	Measures to be implemented	Initial Data	Outcome	Target	Indicator	Responsible and partner organization	Source of funding
Strategic priority 1	**Improvement of coordination in mental health**						
Activity 1	Creation of coordination team for monitoring and evaluation of deinstitutionalization process	Mental health council is functioning for system reform and defining directions of this reform	Coordination team for monitoring and evaluation of deinstitutionalization process is created	2016	Reports of coordination team	Ministry of Labour, Health and Social Affairs of Georgia, Ministry of economics and sustainable development, Ministry of finance, donor and non-governmental organizations, professional associations	State budget, donor organization
Activity 2	Formulation of working groups working on each strategic priority and identification of responsible person per each working group,;	N/A	Working groups with responsible persons for each strategic priorities are defined	2016	Recommendations and reports of working groups by strategic priorities	Members of working groups, mental health council	State budget, Donor organization
Strategic priority 2	**Integration of mental health care in primary health care system**						
Activity 1	Creation of electronic database on number and geographic allocation of primary health care professionals	N/A	Electronic database on number and geographic allocation of primary health care professionals is created	2016	Functioning electronic database of primary health care professionals	Ministry of Labour, Health and Social Affairs of Georgia, regional municipalities, donor and non-governmental organizations	State budget, Donor organization

Activity 2	Training of primary healthcare personnel in identification, management, referral and age-specific skills regarding mental health issues;	General practitioners of Gori, Khashuri, Kareli and Mtskheta are trained by the donor organization	All General practitioners are trained across the country	2018	Detection of persons with mental disorders increased 30%.	Ministry of Labour, Health and Social Affairs of Georgia, Donor organizations, Specialized associations, regional municipalities	Donor organizations, State budget
Activity 3	Elaboration of flexible and sustainable model for collaboration between primary health care and mental health community services	N/A	Flexible and sustainable model for collaboration between primary health care and mental health community services is elaborated, guidelines are developed, and agreements are signed between the parties.	2017	Normative order of the Minister of Labour, Health and Social Affairs of Georgia	Ministry of Labour, Health and Social Affairs of Georgia, Donor organizations, professional associations, service providers	Donor organization, State budget
Activity 4	Provision of supportive supervision for trained primary health care professionals	N/A	Supportive supervision is provided by mental health professionals	2017-2020	Recommendations and reports made during the supportive supervision	Ministry of Labour, Health and Social Affairs of Georgia, Donor organizations, professional associations, service providers	Donor organization, State budget
Strategic priority 3	**Restructuration of existing outpatient mental health service into the community based services**						
Activity 1	Definitions of catchment areas for community services	Catchment areas for community services are not defined	Catchment areas for community services are defined	2016	Normative order of the Minister of Labour, Health and Social Affairs of Georgia, which defines catchment areas for community services	Ministry of Labour, Health and Social Affairs of Georgia, professional associations, donor and non-governmental organizations	State budget
Activity 2	Development/update of	N/A	Standard packages for	2016	Standard packages	Ministry of Labour,	Donor

	standard packages for community based multidisciplinary services (community mental health teams, day care center, psycho-social rehabilitation services)		community based multidisciplinary services developed/updated		are included in the Mental Health State Program	Health and Social Affairs of Georgia, professional associations, donor and non-governmental organizations	organization, State budget
Activity 3	Development of community mental health teams in ambulatory services, considering catchment area	N/A	Community mental health teams in ambulatory services across the country developed and are functioning	2016-2020	Number of community mental health teams functioning within the mental health state program	Ministry of Labour, Health and Social Affairs of Georgia, professional associations, donor and non-governmental organizations	State budget
Activity 4	Development of psycho-social rehabilitation services	Only 3 centers provide psycho-social rehabilitation in the country	Psychosocial rehabilitation services across the country developed and are functioning	2017-2020	Number of new psychosocial rehabilitation service providers funded by mental health state program	Ministry of Labour, Health and Social Affairs of Georgia, professional associations, donor and non-governmental organizations	State budget
Strategic priority 4	**Restructuration of existing hospital beds and creation new ones**						
Activity 1	Integration of psychiatric beds for adult in general hospitals in Tbilisi and regions	1. Total 90 beds, including: 30 beds in #5 Tbilisi Clinical Hospital, 30 beds in Gudushauri Clinic, and 30 beds in Referral Hospital only in Tbilisi	Number of psychiatric beds for adults integrated in general hospitals in Tbilisi and regions increased	2018-2020	1. Number of psychiatric beds for adults integrated in general hospitals 2. Number of regions having psychiatric beds for adults integrated in general hospitals	Ministry of Labour, Health and Social Affairs of Georgia, Ministry of Economics and Sustainable Development, Ministry of Financing, Donor organizations, professional associations, private institutions	State Budget, Donor organizations
Activity 2	Creation of psychiatric beds for adolescents and	10 beds in #5 Tbilisi Clinical Hospital in	Number of psychiatric beds for adolescent and children	2018-2020	1. Number of psychiatric beds	Ministry of Labour, Health and Social	State Budget, Donor

	children in general hospitals in Tbilisi and regions	Tbilisi	integrated in general hospitals in Tbilisi and regions are increased		for adolescent and children in general hospitals, 2. Number of regions having psychiatric beds for adolescents and children integrated in general hospitals	Affairs of Georgia, Ministry of Economics and Sustainable Development, Ministry of Financing, Donor organizations, professional association, private institutions	organizations
Activity 3	Establishment of community residential facilities	No residential facilities in Georgia, except shelters, which is located in psychiatric hospital with 650 beds, where 100 beds is for shelter.	New community residential facilities in Tbilisi and regions are established	2018-2020	1. Number of beds/places in the new community residential facilities 2. Number of regions that have new community residential facilities	Ministry of Labour, Health and Social Affairs of Georgia, Ministry of Economics and Sustainable Development, Ministry of Financing, Donor organizations, professional association, private institutions	State Budget, Donor organizations
Strategic priority 5	**Mental health support and mental disorder prevention**						
Strategic priority 6	**Public awareness rising**						
Activity 1	Carrying public awareness survey (opinions, attitudes, expectation);	N/A	Public awareness survey (opinions, attitudes, expectations) is completed	2016	Survey results	Ministry of Labour, Health and Social Affairs of Georgia, Donor and non-governmental organizations, professional association	
Activity 2	Implementation of informational and educational activities to reduce stigma;	N/A	Informational and educational activities carried out in order to reduce the stigma	2017-2020	1. Number of programs of public awareness raising and stigma	Ministry of Labour, Health and Social Affairs of Georgia, Ministry of Education	

					reduction. 2. Number of Individuals involved.	and Science of Georgia, Donor and non-governmental organizations, professional associations	
Activity 3	Increasing awareness among mass media representatives on key issues of mental health state policy, developing training materials and conduct training	N/A	Training materials are developed, information media tours are held annually for the mass media representatives.	2017-2020	Number of representatives of media, who have undergone training on key issues of mental health policy.	Ministry of Labour, Health and Social Affairs of Georgia, Donor and non-governmental organizations, professional association, mass media representatives	
Strategy monitoring 7	**Development of quality monitoring system**						

Annex 1

Number of population by municipalities (data by the 1st of January[39] (counted thousand people)					
	2013	2014	Best number of multidisciplinary teams	Taking in account number of existing psychiatrists	Regions where psychiatrist will visit locally based family doctor and psychiatric nurse for supportive supervision and consultations
Georgia	**4483.8**	**4490.5**			
Tbilisi	**1171.2**	**1175.2**	**14**	**14**	
Autonomous Republic of Abkhazia	**…**	**…**			
Sukhumi (city)	…	…			
Tkvarcheli (city)	…	…			
Ajara Municipality	…	…			
Gagra Municipality	…	…			
Gali Municipality	…	…			
Gudauta Municipality	…	…			
Gulrifshi Municipality	…	…			
Ochamchire Municipality	…	…			
Sukhumi Municipality	…	…			
Autonomous Republic of Adjaria	**394.2**	**396.6**			
Batumi (city)	160.0	161,2	**2**	**3**	
Kedi Municipality	20.5	20.6	**1**		**x**
Kobuleti Municipality	92.9	93.3	**2**		
Shuakhevi Municipality	22.8	22.9	**1**		**x**
Khelvachauri Municipality	62.1	62,5	**2**		
Khulo Municipality	35.9	36.1	**1**		**x**
Guria	**139.2**	**138.8**			
Lanchkhuti Municipality	38.7	38.6	**1**	**4**	
Ozurgeti Municipality	77.9	77.7	**2**		
Chokhatauri Municipality	22.6	22.5	**1**		
Imereti	**703.9**	**703.3**			
Kutaisi (city)	196.5	197.0	**2**	**10**	
Baghdati Municipality	28.6	28.5	**1**		**x**
Vani Municipality	33.6	33.5	**1**		**x**
Zestafoni Municipality	75.3	75.2	**2**	**3**	
Terjola Municipality	44.8	44.7	**1**		

Samtredia Municipality	60.3	60.1	2	2	
Sachkhere Municipality	48.0	48.1	1		x
Tkibuli Municipality	29.8	29.5	1		x
Tskaltubo Municipality	73.6	73.5	2		x
Chiatura Municipality	54.9	54.9	1		
Kharagauli Municipality	27.2	27.1	1		x
Khoni Municipality	31.3	31.2	1	1	
Kakheti	**405.1**	**405.0**			
Akhmeta Municipality	42.3	42.3	1		x
Gurjaani Municipality	69.2	69.0	2		
Dedoflistskaro Municipality	30.5	30.4	1		
Telavi Municipality	70.9	70.9	2	4	
Lagodekhi Municipality	51.9	52.0	1	3	
Sagarejo Municipality	60.0	60.3	2		
Sighnaghi Municipality	43.4	43.2	1		
Kvareli municipality	36.9	36.9	1		
Mtskheta-Mtianeti	**108.9**	**108.8**			
Akhalgori Municipality	…	…			
Dusheti municipality	33.8	33.6	1	3	
Tianeti Municipality	12.9	12.9	1		x
Mtskheta Municipality	57.3	57.4	2		
Kazbegi Municipality	4.9	4.9	1		x
Racha-Lechkhumi and Kvemo Svaneti	**46.3**	**45.9**			
Ambrolauri Municipality	13.8	13.6	1		x
Lentekhi Municipality	8.9	8.9	1		x
Oni Municipality	8.2	8.1	1		x
Tsageri Municipality	15.4	15.3	1	1	x
Samegrelo and Zemo Svaneti	**476.9**	**476.3**			
Poti (city)	47.7	47.8	1	1	
Abasha Municipality	27.6	27.5	1		x
Zugdidi Municipality	177.2	177.0	2	3	
Martvili Municipality	44.7	44.5	1		x
Mestiis Municipality	14.5	14.5	1	1	x
Senaki Municipality	52.3	52.2	1	3	
Chkhorotsku Municipality	30.7	30.7	1		x
Tsalenjikha Municipality	40.7	40.6	1	1	x
Khobi Municipality	41.5	41.5	1		x
Samtskhe-Javakheti	**213.5**	**213.7**			
Adigeni Municipality	20.8	20.8	1	2	x
Aspindza Municipality	13.2	13.2	1		x
Akhalkalaki Municipality	64.8	64.9	2		
Akhaltsikhe Municipality	48.4	48.5	1		

Borjomi Municipality	31.5	31.4	1		x
Ninotsminda Municipality	34.8	34.9	1		
Kvemo Kartli	**511.1**	**513.1**			
Rustavi (city)	122.5	122.9	2	4	
Bolnisi Municipality	78.6	78.9	2		
Gardabani Muincipality	99.7	100.1	2		
Dmanisi Municipality	28.8	28.8	1		x
Tetritskaro Municipality	28.3	28.3	1		x
Marneuli Municipality	129.8	130.6	2	1	
Tsalka Municipality	23.4	23.5	1		x
Shida Kartli	**313.5**	**313.8**			
Tskhinvali (city)	...	...			
Gori Municipality	145.7	145.8	2	3	
Eredvi Municipality	...	...			
Tighvi Municipality	...	...			
Kaspi Municipality	52.6	52.6	1		x
Kareli Municipality	52.8	52.9	1		x
Kurta Municipality	...	...			
Khashuri Municipality	62.4	62.5	2	1	
Java Municipality	...	...			
			97	68	

Annex 2

Number of Patients admitted in psychiatric hospitals more than 6 months taking into account their place of residence[40]		Location and number of beds for Residential houses
	2014	
Georgia		
Tbilisi	140	140
Autonomous Republic of Abkhazia		
Sukhumi (city)	2	n/a
Tkvarcheli (city)	1	n/a
Ajara Municipality		n/a
Gagra Municipality	1	n/a
Gali Municipality	1	n/a
Gudauta Municipality	2	n/a
Gulrifshi Municipality		n/a
Ochamchire Municipality	1	n/a
Sukhumi Municipality		n/a
Autonomous Republic of Adjara		

Batumi (city)	4	13
Kedi Municipality		
Kobuleti Municipality	1	
Shuakhevi Municipality		
Khelvachauri Municipality		
Khulo Municipality		
Guria		
Lanchkhuti Municipality	2	
Ozurgeti Municipality	5	12
Chokhatauri Municipality	5	
Imereti		
Kutaisi (city)	28	31
Baghdati Municipality	3	
Vani Municipality	9	19
Zestafoni Municipality	5	10
Terjola Municipality	2	14
Samtredia Municipality	10	
Sachkhere Municipality	6	
Tkibuli Municipality	5	
Tskaltubo Municipality	9	21
Chiatura Municipality	1	
Kharagauli Municipality	5	
Khoni Municipality	12	
Kakheti		
Akhmeta Municipality		
Gurjaani Municipality	6	
Dedoflistskaro Municipality	3	16
Telavi Municipality	5	
Lagodekhi Municipality	2	
Sagarejo Municipality	5	
Sighnaghi Municipality	2	
Kvareli municipality	4	11
Mtskheta-Mtianeti		
Akhalgori Municipality	3	
Dusheti municipality	4	12
Tianeti Municipality	1	
Mtskheta Municipality	4	
Kazbegi Municipality		
Racha-Lechkhumi and Kvemo Svaneti		
Ambrolauri Municipality	2	5
Lentekhi Municipality	1	
Oni Municipality	1	
Tsageri Municipality	1	
Samegrelo and Zemo Svaneti		

Poti (city)		
Abasha Municipality	2	
Zugdidi Municipality	16	24
Martvili Municipality	4	
Mestiis Municipality		
Senaki Municipality	14	22
Chkhorotsku Municipality	5	
Tsalenjikha Municipality	3	
Khobi Municipality	2	
Samtskhe-Javakheti		
Adigeni Municipality	2	
Aspindza Municipality	1	
Akhalkalaki Municipality	4	6
Akhaltsikhe Municipality	2	8
Borjomi Municipality	4	
Ninotsminda Municipality	1	
Kvemo Kartli		
Rustavi (city)	18	25
Bolnisi Municipality	2	
Gardabani Muincipality	7	
Dmanisi Municipality	2	
Tetritskaro Municipality	1	
Marneuli Municipality	5	9
Tsalka Municipality	39	40
Shida Kartli		
Tskhinvali (city)		
Gori Municipality	9	
Eredvi Municipality		
Tighvi Municipality		
Kaspi Municipality	1	
Kareli Municipality	3	
Kurta Municipality		
Khashuri Municipality	8	31
Java Municipality		
homeless	10	
Total	**469**	**482**

Annex 3

Distribution of psychiatric beds before and after creation residential facilities			
Name of the facility	**existing inpatient beds**	**number of beds for residential facilities**	**after creation of residential facilities**
LTD "Tbilisi Mental Health center"	220	83	137
LTD "Center of Mental Health and Prevention of Addiction"	80	10	70
LTD "The National Center of mental Health of Acad. Bidzina Naneishvili"	650	198	452
LTD "A. Kajaia Surami Psychiatric Hospital"	90	54	36
LTD "Bediani Psychiatric Hospital"	120	112	8
LTD "Republic Clinical Psychological Hospital"	150		150
LTD "Kutaisi Mental Health Center"	30	3	27
LTD "Senaki Interregional Psychoneurological Clinic"	15	0	15
LTD "Academican O. Gudushauri National Medical Center"	0	0	0
LTD "N5 Clinical Hospital"	0	0	0
LTD "Sunstone Medical"	0	0	0
LTD "Rustavi Mental Health Centre"	22	7	15
Total number of beds	**1377**	**467**	**910**

Annex 4

Monitoring scheme of the State Program on Mental Health

1. Programatic management of the state program includes supervision of the execution of the objectives of the program;

2. In the Ministry of Labour, Health and Social Affairs of Georgia, the responsible department of management of the public healthcare programs is Healthcare Department.

3. The program management ensures cooperation between the Healthcare Department, Social Service Agency (agency that transfers money for service delivery), State Regulation Agency for Medical Activities and other stakeholders.

4. In order to supervise the program, for each component is set up the monitoring groups, in which the members of Healthcare Department, Social Service Agency, State Regulation Agency for Medical Activities and other stakeholders are involved.

5. The monitoring team shall be obliged:

a) In order to plan proper data collection about people with mental disorders, to create electronic database;

b) To analyze the provided information;

c) To develop appropriate recommendations to address existing gaps in the program;

d) To ensure effective coordination of the parties involved in program management;

6. Social Service Agency shall be obliged:

a) To ensure the organization of public procurement;

b) To ensure the timely contract signing procedures;

c) To provide detailed information about progress and implementation of the program, according to the agreed form;

7. State Regulatory Agency for Medical Activities shall be obliged:

a) To supervise the implementation of contractual obligations and to ensure inspection of each program component in accordance with the terms of the agreement;

b) In case of failure the terms of the contract, to submit a reasoned recommendation of contract termination and determination of appropriate penalties;

c) To prepare the organizational and methodological recommendations to improve the quality of the work for service providers and for the improvement of program evaluation;

8. Service provider shall be obliged:

a) To perform duties in line with the laws and regulations of the country;

b) To ensure a complete and high-quality delivery of services provided by the program;

c) To protect the interests and rights of patient's related to their health and social conditions;

Annex 5

Patient satisfaction questionnaire – short version (PSQ-18)

Type of medical service	
Time of treatment episode	beginning: *(day/month/year)* ending: *(day/month/year)*
Age of patient	
Gender of patient	female ☐ male ☐

N		Strongly agree	Agree	Uncertain	Disagree	Strongly disagree
1	Doctors are good about explaining the reason for medical tests	1	2	3	4	5
2	I think my doctor's office has everything needed to provide complete medical care	1	2	3	4	5
3	The medical care I have been receiving is just about perfect	1	2	3	4	5
4	Sometimes doctors make me wonder if their diagnosis is correct	1	2	3	4	5
5	I feel confident that I can get the medical care I need without being set back financially	1	2	3	4	5
6	When I go for medical care, they are careful to check everything when treating and examining me	1	2	3	4	5
7	I have to pay for more of my medical care than I can afford	1	2	3	4	5
8	I have easy access to the medical specialists I need	1	2	3	4	5
9	Where I get medical care, people have to wait too long for emergency treatment	1	2	3	4	5
10	Doctors act too businesslike and impersonal toward me	1	2	3	4	5
11	My doctors treat me in a very friendly and courteous manner	1	2	3	4	5
12	Those who provide my medical care sometimes hurry too much when they treat me	1	2	3	4	5
13	Doctors sometimes ignore what I tell them	1	2	3	4	5
14	I have some doubts about the ability of the doctors who treat me	1	2	3	4	5
15	Doctors usually spend plenty of time with me	1	2	3	4	5
16	I find it hard to get an appointment for medical care right away	1	2	3	4	5
17	I am dissatisfied with some things about the medical care I receive	1	2	3	4	5
18	I am able to get medical care whenever I need it	1	2	3	4	5

References

[1] *Global burden of disease attributable to mental and substance use disorders: findings from the Global Burden of Disease Study 2010, Whiteford, Harvey A et al. The Lancet , Volume 382 , Issue 9904 , 1575 - 1586*
[2] *Scotish Association for Mental Health SAMH (2006), What's it worth? The Social and Economic Costs of Mental Health Problems in Scotland, report, Glasgow;*
[3] *World Health Organization (2003), Mental Health in the WHO Eropean Region, Fact Sheet Copenhagen, Vienna;*
[4]*World Health repot 2001: mental health: new understanding, new hope Geneva, World Health Organization (*http://www.who.int/whr2001/2001/main/en*). Geneva, World Health Organization, 2001 (accessed 13 July 2003);*
[5] *Thornicroft G, Tansella M (2003) What Are the Arguments for Community-based Mental Health Care? Health Evidence Network;*
[6]*McDaid Thornicroft, 2005. Reorganization of mental health care, Policy Brief, European Observatory on Health Systems and Policies;*
[7] *Tomov, T. et al. (2005.) Mental health policy in former Eastern bloc countries. In: Knapp M et al., (eds.), Mental Health Policy and Practice Across Europe. Buckingham, Open University Press;*
[8] *McDaid, D. et al (2005), Funding Mental Health, Europen Observatory on Health Systems and Policies;*
[9] *McDaid, D. and Thornicroft, G., (2005). Policy brief; Mental health II; Balancing institutional and community-based care, World Health Organization, on behalf of the European Observatory on Health Systems and Policies;*
[10] *Thornicroft G, Tansella M (2003) What Are the Arguments for Community-based Mental Health Care? Health Evidence Network;*
[11] *http://www.euro.who.int/document/hen/mentalhealth.pdf*
[12] *WHO (2013) Mental Health Action Plan 2013-2020; WHO-Geneva*
[13] WHO Mental Health Action Plan 2013-2020. WHO-Geneva
[14] *World Health Report 2001. Mental Health: New Understanding, New Hope. WHO-Geneva;*
[15] *Ibid*.
[16] See Thornocroft G. and Tansella M. (2012). Better mental health care. Tbilisi. P. 10
[17] *Ibid.*
[18] *WHO (2005) Mental Health Atlas. WHO- Geneva;*
[19] Global Initiative on Psychiatry – Tbilisi (2008). "Better mental health for vulnerable groups of population. Condition and needs of persons with mental disorders in Georgia". Analytical report. Tbilisi.
[20] *WHO (2011) Mental Health Atlas. WHO-Geneva;*
[21] WHO Mental Health Action Plan 2013-2020. WHO-Geneva
[22] "Organization of Services for Mental Health", Mental Health Policy and Service Guidance Package, WHO, 2003.
[23] *Mental Health Atlas 2011*
[24] National center for disease control and public health, statistical yearbook 2013.
[25] National center for disease control and public health, statistical yearbook 2013.
[26] Global Initiative on Psychiatry – Tbilisi (2008). "Better mental health for vulnerable groups of population. Condition and needs of persons with mental disorders in Georgia". Analytical report. Tbilisi.
[27] Global Initiative on Psychiatry – Tbilisi (2008). "Better mental health for vulnerable groups of population. Condition and needs of persons with mental disorders in Georgia". Analytical report. Tbilisi
[28] Mental Health Atlas 2011 - World Health Organization http://whqlibdoc.who.int/publications/2011/9799241564359_eng.pdf;
[29] http://cloud.moh.gov.ge/Pages/AdvSearchPage.aspx; Information portal of the Ministry of Labour, Health and Social Affairs of Georgia, the information is verified with directors of the facilities.
[30] World health statistics 2012, Global health indicators – part III;
[31] http://www.ombudsman.ge/uploads/other/0/100.pdf
[32] Council of Europe (2013) Assessment of Quality of Mental Health Services
[33] Recommendation Rec(2004)10 of the Committee of Ministers to member states concerning the protection of the human rights and dignity of persons with mental disorder
[34] Ombudsman's annual report about Human Rights Situation in Georgia, 2012.
[35] Organization of Services for Mental Health, Mental Health Policy and Service Guidance Package, WHO, 2003.
[36] Graham Thornicroft and Michele Tansella, Better Mental Health Care; 2009;

[37] Sytema S, Micciolo R and Tansella M. Continuity of care for patients with schizophrenia and related disorders: a comparative south-Verona and Groningen caseregister study. Psychol. Med. 1997; 27(6): 1355-1362;
[38] Crisp et al, 2005
[39] Number of Georgian population by municipalities - http://geostat.ge/?action=page&p_id=472&lang=geo
[40] Information is provided by the psychiatric hospitals.